97th Congress
2d Session

COMMITTEE PRINT

CP 97-12

Proposed Prospective Reimbursement Rates for the End-Stage Renal Disease (ESRD) Program Under Medicare

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PREPARED BY THE STAFF FOR THE USE OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ROBERT J. DOLE, *Chairman*

MARCH 1982

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1982

91-216 O

5362-7

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PREFACE

This document has been prepared for the use of the Committee on Finance in conjunction with its Subcommittee on Health hearing to review the proposed prospective reimbursement rates for the end-stage renal disease program. The hearing is the second part of a hearing which began September 28, 1981.

A committee print titled, "End-Stage Renal Disease (ESRD) Program Under Medicare," issued in conjunction with the part I hearing, provides a brief legislative history of the program, and outlines program benefits, operations, and existing reimbursement policies.

This document outlines the proposed regulations which would change the reimbursement system by which medicare pays for outpatient dialysis and related physician and laboratory services and provides a brief description of the rate-setting methodologies. The opinions and conclusions contained in the Secretary's Notice of Proposed Rulemaking reflected in sections II, III, IV, and V of this document are not necessarily those of the committee. Issues of note related to the proposed rule are presented in section VI.

The committee wishes to acknowledge the assistance of the Senate Computer Center in the preparation of this document.

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I. BACKGROUND

As part of the End Stage Renal Disease Amendments of 1978, the Secretary was required to implement incentive reimbursement rates to assure most cost-effective delivery of services to patients dialyzing in facilities or at home. Implementation was delayed until audits could be conducted to establish the basis on which separate rates for independent and hospital-based facilities could be developed. Before these rates were published, controversy arose as to whether separate rates or a single rate for all facilities should be established. The administration subsequently proposed to establish a single reimbursement rate for such services, applicable to all facilities that would be set at 120 percent of the cost experience of the less expensive independent facilities.

Congress, however, expressed concern about the administration proposal, noting that it could have a negative impact on the continued participation of hospital-based facilities and on the objective of encouraging lower cost home dialysis. As a result, Congress further amended the law (through the Omnibus Budget Reconciliation Act of 1981, Public Law 97–35) to require the Secretary to establish prospectively determined rates on the basis of separately calculated composite weighted formulas for hospital-based facilities and for independent facilities. These formulas are to take into account the proportions of patients dialyzing in a facility and those dialyzing at home and the relative costs of providing services in each of these settings.

The legislation required the Secretary to issue implementing regulations by October 1, 1981. However, the new regulations were delayed while the Secretary conducted additional audits to establish the cost-of-home dialysis. On February 12, 1982, the administration published a proposed rule to change the reimbursement system by which medicare pays for outpatient dialysis and related physician and laboratory services. The public has 60 days in which to provide comments.

II. PROPOSED REGULATIONS

The proposed regulations include general provisions on the payment methods for both facilities and physicians, but do not include full details of the rate-setting methodologies. The methodologies are expected to change over time as a result of continued review and an updating of the data on which they are based. Although the regulations set forth only general principles and authorities governing payment methods, they also provide for facility recordkeeping and reporting requirements, appeals, notification and revision of the payment methodologies and rates, and exceptions to the dialysis treatment rates.

Payment for Dialysis Treatment

The proposed regulations state that the Health Care Financing Administration (HCFA) has the authority to establish rate-setting methodologies and set rates in accordance with section 1881 of the Social Security Act, and would specify how the amount of program payments and beneficiary liability will be determined based on a prospective payment rate. This provision would require all dialysis facilities to accept these prospective payment rates as payment in full; beneficiaries will continue to be liable for part B deductible obligations plus a coinsurance amount of 20 percent of the rate for each treatment. After the deductible obligation is incurred, the ESRD program would be responsible for 80 percent of all payments due to the facility for covered services furnished.

Under the proposed rules and before exceptions are considered, the average payment per treatment for hospital-based facilities would be $132. The average payment for independent facilities would be $128. In practice per treatment payments for hospital-based facilities would range from a low of about $114 to a high of about $146, depending on geographic differences in the costs of labor. Similarly, independent facility payments would vary from $109 to $143 per treatment.

Under existing rules hospital-based facilities received an average $159 per treatment in 1980, independent facilities received an average $138 per treatment. The higher rate for hospital-based facilities was the result of exceptions which allowed per treatment reimbursements to exceed the established $138 limit.

Payments for home dialysis treatments, where the equipment, supplies and support services are provided through a facility would be made at the same rate as in-facility treatment ($128 or $132) under the new rule. Since home dialysis is less costly than in-facility treatments, the composite rates offer an incentive to shift those patients who are medically, socially, and psychologically suited to home care. Previous methods for reimbursing the costs of home care would be abandoned. However, as currently allowed by law, home patients would retain the right to directly bill the medicare program for supplies and equipment. (The care for these patients would not be reimbursed through a facility at the composite rate.)

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Under the proposed reimbursement system, the existing medicare provision for a return on equity capital to proprietary hospitals will not be applied to ESRD facilities. The purpose of the return on equity provision is to permit payment of an amount above costs to proprietary providers. Since the purpose of the prospective reimbursement rate would be to give ESRD facilities an incentive to reduce costs to realize a profit from the rate, a return on equity capital for proprietary hospital-based and independent facilities is regarded as inappropriate.

The existing medicare provision which allows providers, including hospitals with ESRD facilities, to make a specific writeoff of medicare bad debts will be applied to all ESRD facilities. Under current regulations, independent facilities absorb bad debts. However, under the proposed system, HCFA will pay all ESRD facilities 100 percent of allowable medicare bad debts, up to their reasonable costs, in a separate yearend payment.

Exceptions

Under the proposed rules, the exception process will be more stringent and less exceptions are expected to be granted. Exceptions will be considered for a facility that is able to provide convincing objective evidence that it has excessive costs attributable to one of the following conditions.

Atypical patient mix.—When compared to average facilities, a facility might have a mix of patients requiring intensive services, or special procedures or supplies. Any facility claiming to meet this criterion must demonstrate that its excess costs are not out of line with the standards of other facilities with a similar patient mix.

Extraordinary circumstances.—A facility may incur excess costs beyond its control due to a fire, earthquake, flood, or other natural disasters which could establish grounds for an exception. However, such costs would not be recognized in cases when a facility chose not to maintain adequate insurance protection against such losses or chose not to utilize a self-insurance program.

Isolated essential facilities.—A facility could justify an exception under this criterion if:

It is the only supplier of dialysis services in its geographical area,

Its patients cannot obtain dialysis services elsewhere without substantial additional hardship, and

Its costs in excess of its payment rate are justifiable.

Education costs.—A facility may qualify for an exception if its excess costs are attributable to an approved medical or paramedical education program that directly involves outpatient dialysis services. Any increase would be allowed only for the incremental amount of the facility's costs that are directly attributable to its educational program, and only for the amount that could be properly allocated to the outpatient dialysis department.

Appeals

Any facility whose request for payment above the prospective rate is denied in total, or is not met to the facility's satisfaction, could request a review by the intermediary, the Provider Reimbursement Review Board (PRRB) and the Administrator, Health Care Financing Administration. A facility would be permitted to appeal either exception determinations or cost report adjustments to the PRRB, however, only if the total amount in controversy were $10,000 or more.

Recordkeeping and Reporting

The proposed regulations clarify requirements for recordkeeping and reporting systems for ESRD facilities to provide a sound basis for monitoring and evaluating the program generally and determining appropriate medicare payment rates under prospective reimbursement.

Although following the medicare principles of cost reimbursement generally, for reporting ESRD costs, the regulations exclude (1) certain principles that are not applicable to the proposed incentive reimbursement system, and (2) procedural requirements or provider reimbursement principles not applicable to maintenance dialysis services. However, some sections contain principles on determining what costs are allowable under medicare which are applicable to the proposed system. In that case HCFA has restated them in the proposed rule.

In addition, the proposed regulations clarify the existing requirement that a facility report costs for home dialysis, outpatient dialysis, and self-care dialysis training.

Notification and Revision of Methodologies and Rates

The regulations governing reimbursement for both dialysis treatment and physician services would not incorporate the actual rate-setting methodologies, but would provide that, if HCFA planned to change these methodologies, HCFA would publish in the Federal Register for public comment a notice setting forth the proposed changes. However, HCFA would not necessarily publish a proposed notice to change only the payment rates by applying the established methodology to more recent data. HCFA proposes to have the intermediaries notify each facility of its payment rate annually, whether or not the rates are updated.

Home Target Rate Reimbursement

The current optional target rate payment method requires HCFA to establish target reimbursement rates for home dialysis patients under the direct supervision of a hospital-based or independent renal dialysis facility. This is only an optional reimbursement method for facilities that make an agreement with HCFA to furnish all home dialysis supplies, equipment, and support services (including the services of qualified home dialysis aides) that are medically necessary for

patients to dialyze at home. Since home dialysis will be covered under the proposed prospective rates, continuing the target rate system would provide an alternative to reimbursing home dialysis that would compete against the more effective proposed composite rate. Therefore, HCFA proposes to discontinue the target rate payment method.

One Hundred Percent Cost Reimbursement for Home Dialysis

The 1978 ESRD Amendments provided that, under certain circumstances, the Secretary may reimburse the full cost of home dialysis equipment, installation, maintenance, and repair. In the absence of an agreement for this purpose, the program pays rental charges or periodic lease-purchase charges (on a reasonable charge basis to suppliers and independent facilities and on a reasonable cost basis to hospital-based facilities) at the rate of 80 percent.

HCFA proposes to discontinue this option when the prospective system begins operation. Therefore, equipment furnished on or after the effective date of the prospective system would no longer be reimbursable at 100 percent. HCFA believes that the prospective rates will establish sufficient incentive for home dialysis and that the 100 percent reimbursement option creates added program expenses that are no longer warranted.

Standards for Identifying Hospital-Based Facilities

Because the rates set under the proposed methodology would pay more for treatments furnished by hospital-based facilities, the new regulations provide clear and unambiguous standards for determining which facilities would be eligible for these higher rates. An ESRD facility will be determined to be hospital-based if it is an integral and subordinate part of a hospital and is operated with other departments of the hospital under common licensure, governance, and professional supervision, with all services of the hospital and facility fully integrated.

Physician Reimbursement

The new regulations equalize physician reimbursement for in-facility and home dialysis patients in order to eliminate the present economic disincentive for moving patients to the home setting. They promote the increased use of home dialysis by eliminating the initial (fee-for-service) method and establishing equal physician capitation monthly payments for home dialysis and in-facility dialysis.

Under the proposed rules all physician reimbursement for direct patient care services related to home or in-facility dialysis treatments would be paid on the basis of a single monthly capitation payment, similar to the current alternative reimbursement method (ARM). Currently ARM payments range from $180 to $260 for in-facility services and from $126 to $182 for home services. The new rate would be $184 for in-facility and home services.

III. FACILITY RATE SETTING METHODOLOGY

The proposed rule establishes a prospective rate setting methodology for dialysis treatments that distinguishes to some extent between hospital-based and independent facilities. The methodology provides a composite rate for home and in-facility treatments based on cost data obtained on a sample basis from facilities providing in-facility and home treatments.

Method of Determining Costs of Outpatient Treatment

In March 1980, HCFA selected a stratified sample of 110 facilities from the total universe of 825 non-Federal ESRD facilities furnishing in-facility outpatient maintenance dialysis sessions. The sample included 70 of the 537 hospital-based facilities and 40 of the 288 independent facilities in the universe. After the sample was selected, personnel from selected medicare intermediaries, supervised by HCFA central office representatives, audited or reviewed the ESRD costs reported by each selected facility. For each independent facility, the intermediaries reconciled the reported ESRD costs directly to the facility's financial records, using either its general ledger or an audited financial statement. For each hospital-based facility, the intermediaries performed a desk review and reconciled the reported ESRD costs to the hospital's previously-submitted and reviewed medicare cost report. The intermediaries determined reasonable costs by the medicare principles of provider reimbursement. The final results include cost data on 67 hospital-based facilities and 38 independent dialysis facilities. Three hospital-based facilities, were excluded from the sample because they did not, in fact, furnish enough outpatient treatments. Two independent facilities were excluded because the information they reported was not sufficient to determine their actual allowable costs.

The audits resulted in adjustments to independent facilities that reduce the total reported costs for all independent facilities by about 15.0 percent of the total ESRD costs reported. Less than 1 percent was eliminated because of reconciliation of reported costs to the general ledger or audited financial statement. The remaining adjustments, about 14 percent of total costs, were made to exclude costs that are not allowable under medicare.

(See Issues of Note, item (a).)

The median cost of the independent facilities was approximately $108 after adjustments. The facilities' costs ranged from a low of $80 per treatment to a high of $214 per treatment.

The net effect of the adjustments to the reported costs of the hospital-based facilities was a reduction of about 3 percent. These adjustments were primarily due to eliminating inpatient hospital costs from the outpatient renal department. The median cost of the hospital-based facilities was approximately $135 per treatment, with a range of $86 to $277.

After the audits were completed, HCFA performed the following steps on the data for each sampled facility:

1. Subtracted from each facility's adjusted total outpatient costs:

   (a) All costs for physicians' direct patient care (supervisory) services, if physicians were reimbursed on a fee-for-service basis; and

   (b) Any excessive compensation paid to an administrator or medical director.

   The most significant adjustment to the audited costs of the independent facilities concerned compensation of administrators and medical directors. HCFA applied a limit of $32,000 per year to these positions, which is the limit applied to administrators of 50 to 99 bed hospitals in Federal Region I, the region with the highest compensation allowances.

2. Added an adjustment amount to represent the cost of routine ESRD laboratory tests for the sampled independent facilities that did not have laboratory costs to report.

3. Divided the resulting net total cost by the corresponding number of outpatient maintenance dialysis treatments to arrive at a net total cost per treatment (CPT) for each facility.

4. Divided each facility's net total cost into labor and nonlabor components and determined the ratio of labor cost to total costs.

5. Multiplied the CPT for each facility by the labor cost ratio for that facility to arrive at the labor cost per treatment.

6. Subtracted the labor CPT from the net total CPT to determine the nonlabor CPT. (Nonlabor costs included supplies, medications, machine costs, such as depreciation, rental, and maintenance, and the nonlabor portions of routine laboratory services, general overhead, and other indirect costs.)

7. Divided each facility's labor CPT by the appropriate area wage index to adjust for geographic wage differences.

HCFA's audits of ESRD in-facility costs showed that costs incurred by hospital-based facilities were generally higher than costs incurred by independent facilities. Dividing all costs into three components—labor, overhead, and supplies—median costs per treatment for hospital-based facilities exceeded median costs for independent facilities by the following amounts:

a. Labor	$20.00
b. Overhead	$7.50
c. Supplies	$4.00

NOTE.—Portions of reported overhead are also included in the labor cost. Therefore, the sum of a, b. and c ($31.50) is greater than the difference ($27.45) between the median costs per treatment at $107.66 for independent facilities and $135.11 for hospital-based facilities.

Method of Determining Cost of Home Dialysis

HCFA selected 23 dialysis facilities and two state kidney programs around the country that had home programs to obtain accurate data on the cost of home dialysis. Although the facilities represented less than 5 percent of the total number of ESRD facilities with home programs,

the sample included 10 of the 13 largest home programs and represented almost 30 percent of all home patients.

The objectives of these cost reviews were first, to determine the average costs per treatment of home dialysis by mode of treatment (that is, hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), or intermittent peritoneal dialysis (IPD), and second, to break down these costs per treatment into labor and nonlabor costs components. Due to severe time constraints, it was impossible to actually determine if all costs were reasonable and allowable under medicare principles of reimbursement, or to establish rigorous comparable cost centers in any detail. However, HCFA believes the cost review results reasonably represent the median costs of furnishing home dialysis. When weighted in proportion to the estimated percentage of patients treated under each mode, the cost per treatment for home dialysis is about $97, of which around $12 per treatment is labor costs, and $85 per treatment nonlabor costs.

Establishment of Rates for Independent and Hospital-Based Facilities

Based on the statute as a whole, HCFA concluded that Congress intended setting rates that are economic and that at the same time differentiate between hospital-based facilities and independent facilities based on justifiable differences in costs incurred by each type of facility. Therefore, HCFA's basic approach was to identify the legitimate costs of what appeared to be economically and efficiently operated dialysis facilities and then, in setting the rates, to make adjustments to reflect costs or savings attributable to operations as a hospital-based facility or as an independent facility.

(See Issues of Note, item (b).)

HCFA, as the first step in setting the rate, ascertained an efficient level of costs by considering the actual costs of *all* facilities subject to the audits—both hospital-based and independent. HCFA proposes to consider the median costs of these combined facilities to approximate the economic costs of providing dialysis services.

Next, HCFA identified legitimate cost differences attributable to operations as hospital-based or independent facilities. As noted above, median hospital costs identified in the audits exceeded median independent costs in every category. Some of these excess costs were implicitly recognized through inclusion of hospital-based facilities in the sample of audited facilities. The Secretary considered whether any additional excess costs incurred by hospital-based facilities should be more fully recognized. Specifically the proposed rule states that:

> There is no justification for hospital-based facilities as a class to pay more for supplies than independent facilities, since the supplies are identical. While the independent facilities may make greater use of volume purchasing, there is no reason to conclude that hospitals that fail to do so to a similar extent are operating efficiently.
>
> (See Issues of Note, item (c).)
>
> Some hospital units claim that one reason they have higher labor costs than independent facilities is that they treat more

patients with multiple conditions or other complications that require more highly trained staff and more staff per patient. HCFA examined age, sex, race, and utilization rate (discharges and days of care) differences between hospital-based and independent facilities. Because the differences were small and did not approach statistical significance, HCFA concluded that with respect to these measures of patient need, there is not great difference between hospital-based and independent facilities.

(See Issues of Note, item (d).)

Some hospitals claim that medicare cost-finding and reporting procedures require the allocation of excess overhead costs to their outpatient renal dialysis units. HCFA believes this claim to be valid, and proposes to allow the hospitals the additional overhead. This differential is $2.10 per treatment between the median costs of hospitals alone and the median of the combined sample of hospitals and independent facilities.

(See Issues of Note, item (e).)

Composite Rates for Home and In-Facility Dialysis

The Omnibus Budget Reconciliation Act of 1981 gives preference to a rate-setting methodology that combines the cost of in-facility dialysis and the cost of home dialysis into a composite rate that would be paid to a facility for all treatments, whether furnished in the facility or in the home. In computing a composite rate, the percentage of home dialysis patients served by hospitals was applied to calculate the hospital composite rate, and the percentage of home dialysis patients served by independent facilities to calculate the independent facility composite rate.

(See Issues of Note, item (f).)

Adjustments for Geographic Wage Differences

To reflect local wage differences, the proposed methodology adjusts payments by an area wage index originally developed to determine medicare cost limits for hospitals.

Under the proposed prospective reimbursement system, the area wage indices are used in two ways. First, to make the per treatment costs for each sampled facility comparable so that median costs could be determined. To do this the labor portion of costs for each sampled facility are divided by the appropriate area wage index, so that differences due to local wage levels are minimized.

Second, to calculate an actual payment rate per treatment for a particular facility. After median costs have been adjusted for dialysis setting (home vs. infacility), overhead, and methodological shortcomings, the methodology produces base rates for both types of facilities. The base rate components for labor costs are multiplied by the appropriate area wage indices. This reintroduces a consideration of local wage levels, insuring that a facility in an area of high labor costs will not be paid an inappropriately uniform rate.

Other Adjustments in Setting the Rate

After determining the median costs per treatment for dialysis in hospital-based and independent facilities, the analysis proceeded on the assumption that the median cost incurred by all the audited facilities was a good approximation of the legitimate costs of economic operation. However, the use of a percentage below or above the median to account for possible deficiencies in the audit data or to accommodate other pertinent considerations was considered. It was decided not to make any adjustment in the case of the independent facilities. Although the median selected, which includes both hospital-based and independent facilities ($126), is significantly higher than the median for independent facilities alone ($108), a downward adjustment was not made. The omission of such an adjustment was to account for any deficiencies in the data used.

The rate for hospital-based facilities was adjusted upward to 105 percent of the median costs. This adjustment was made to accommodate the possibility that the methodology failed to recognize fully the legitimate costs of hospitals, either because of shortcomings in, or the age of, the data and the fact that the compositing structure forces the hospital rates below the median costs of all facilities.

(See Issues of Note, item (g).)

An adjustment to account for inflation since the audits were conducted was deemed to be inappropriate. The evidence indicates that the provision of dialysis services has been characterized by increased efficiencies. The payment screen has been $138 since 1974. Despite the general inflation since then, a large number of independent dialysis facilities have been opened during the period.

NUMBER OF DIALYSIS FACILITIES

	1973	1978	1979	1980	1981
Hospital-based	536	638	645	649	654
Independent	68	275	330	405	466
Total	604	913	975	1,054	1,120

Details of Proposed Methodology and Rates

The data from the facility audits and home dialysis cost studies was used to establish the cost components from which national payment rates would be derived.

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COST COMPONENTS USED TO DERIVE PAYMENT RATES

	Median costs per treatment		
	Adjusted labor cost	Nonlabor cost	Total
All facilities	$54.06	$71.47	$125.53
Independents	40.79	66.87	107.66
Hospital-based	61.17	73.94	135.11
Home dialysis cost (all)	11.70	85.09	96.79
Overhead cost differential of hospitals over all facilities		2.10	

	Location of patients, percent	
	Home	In-facility
Independents	10.5	89.5
Hospital-based	23.5	76.5
Total	17.0	83.0

The above cost components were used to derive prospective base rate components as explained below.

DERIVING THE INDEPENDENT FACILITY RATE

1. The nonlabor composite cost component was computed by multiplying the median of the nonlabor cost per treatment for all facilities ($71.47) by the national percentage of independent facility patients dialyzing on an outpatient basis in the facility (0.895), and adding the result to the product of the median nonlabor cost of home dialysis ($85.09) and the national percentage of independent facility patients dialyzing at home (0.105).

$$(\$71.47 \times 0.895) + (\$85.09 \times 0.105) = \$72.90$$

2. The labor composite cost component was computed by multiplying the median of the labor costs for all facilities ($54.04) by the national percentage of independent facility patients dialyzing on an outpatient basis (0.895), and adding the result to the product of the median adjusted labor cost of home dialysis ($11.70) and the national percentage of independent facility patients dialyzing at home (0.105).

$$(\$54.06 \times 0.895) + (\$11.70 \times 0.105) = \$49.61$$

3. Using these components, the actual payment rate for an individual independent facility would be calculated by multiplying the labor composite cost component ($49.61) by the appropriate area wage index and adding the result to the nonlabor composite cost component ($72.90).

DERIVING THE HOSPITAL-BASED FACILITY RATE

1. The nonlabor composite cost component was computed in several steps. First, the hospital overhead cost differential ($2.10) was added to the median nonlabor cost per treatment for all facilities ($71.47). This was then multiplied by 1.05 (105 percent) and by the national percentage of hospital-based facility patients who dialyze in the facility (0.765). The result was added to the product of the median nonlabor cost per treatment of home dialysis ($85.09) multiplied by 1.05 and by the national percentage of hospital-based facility patients who dialyze at home (0.235).

$$((\$71.47+\$2.10) \times 1.05 \times 0.765)+(\$85.09 \times 1.05 \times 0.235)=\$80.09$$

2. The labor composite cost component was computed by multiplying the median of the labor cost per treatment for all facilities ($54.06) by 1.05 and by the national percentage of hospital-based facility patients who dialyze in the facility (0.765), and adding the result to the product of the median labor cost per treatment of home dialysis ($11.70) multiplied by 1.05 and by the national percentage of hospital-based facility patients who dialyze at home (0.235).

$$(\$54.06 \times 1.05 \times 0.765) + (\$11.70 \times 1.05 \times 0.235) = \$46.31$$

3. Using these components, the payment rate for an individual hospital-based facility would be calculated by multiplying the labor composite cost components ($46.31) by the appropriate area wage index and adding the result to the nonlabor composite cost component ($80.09).

SUMMARY OF THE PROPOSED RULES

The following prospective base rate components were derived as explained above.

	Labor component	Nonlabor component	Total base rate
Independent facilities	$49.61	$72.90	$122.51
Hospital-based	46.31	80.09	126.40

The actual payment for each facility will be calculated by adjusting the labor component by an area wage index. Because most ESRD facilities are located in areas that have a wage index value different than 1.0, the area wage index introduces a substantial variation among the actual rates paid. The average payment per treatment for independent facilities would be around $128, ranging from a low of around $109 to a high around $143. The average payment per treatment for hospital-based facilities would be around $132, ranging from a low of around $114 to a high around $146.

IV. PHYSICIAN RATE-SETTING METHODOLOGY

The proposed rule establishes a prospective rate setting methodology for physicians that equalizes payments for services provided to home and in-facility dialysis patients, and that reflects current practice more accurately. The initial method, under which physicians can only be paid for the actual "hands-on" services they furnish on a fee-for-service basis, will be abandoned.

Current Rate-Setting Under the Alternative Reimbursement Method

The ARM monthly allowance is currently based on prevailing charges for a medical specialist's brief followup office visit with an established patient.

The prevailing charge for a visit or other physician service, before adjustment for an economic index, is calculated at the 75th percentile of physicians customary charges. The Social Security Act and HCFA regulations further require that the prevailing charge for a service in a locality not exceed the level in effect for that service in the locality on June 30, 1973, except to the extent justified on the basis of appropriate indicators of economic change. The economic index adjustment is published in the Federal Register each year.

For a particular locality, the prevailing charge for a brief followup visit is multiplied by 20 for in-facility dialysis, and by 14 for home dialysis, subject to a maximum monthly allowance of $160 and $182 respectively. These monthly payments are not automatically updated by the economic index used to adjust prevailing charges for fee-for-service physician payments under medicare part B. Instead, they are updated as necessary to reflect changes in charging practices and modes of furnishing services, and to assure fairness.

Currently, these payments range from $180 to $260 for in-facility dialysis and from $126 to $182 for home dialysis.

Proposed Rate-Setting Methodology

Typically, patients dialyze between 2 and 3 times per week. Some patients dialyze routinely at a frequency of twice per week, while some patients occasionally miss a dialysis session. At the same time, the physician monthly payment represents payment for some services that may be furnished at a time other than during a dialysis. As a balance between these two considerations the monthly payment will be based on 149 dialysis sessions per patient per year, or 12.4 dialysis sessions per patient per month, and a monthly routine examination.

The national average monthly capitation rate is expected to be $184.08 computed as follows:

Median prevailing charge for a brief followup office visit ($13.96) times 12.4	$173.10
Plus: Median prevailing charge for an intermediate followup office visit	20.87
Total	$193.97

This amount is then apportioned based on the national home (0.17) and in-facility (0.83) dialysis rates:

Home:

$193.97 times 0.17	$32.97	
Reduced by 7/10ths: $32.97 times 0.7		23.08
In-facility: $193.97 times 0.83		161.00
National average monthly rate		$184.08

Once a physician's rate is set by this methodology, it will be held constant until the Secretary determines that the data justifies an update. There will be a regular review of physician reimbursement at the same times that the prospective payment rates for facility dialysis services are reviewed.

V. ADDITIONAL ISSUES

The proposed rule discusses the following additional issues related to implementing the proposed changes in the reimbursement system.

Self-Care Dialysis Training

Self-care dialysis training sessions have always been reimbursed based on a screen that is $20 more than the screen amount applicable to outpatient maintenance dialysis, except when an exception has been approved. In the absence of reliable costs data to the contrary, self-dialysis and home dialysis training sessions would be reimbursed by an amount $20 more than the prospective rate for outpatient maintenance dialysis sessions. Facilities that have justifiable costs greater than this will continue to be able to apply for an exception.

Peritoneal and New Dialysis Techniques

In the absence of cost data to the contrary the reimbursement for intermittent peritoneal dialysis (IPD) will continue to be set in relation to the rate for hemodialysis.

	Treatments (per week)	Reimbursement basis
Treatment duration:		
10 to 12 hours	3	1.0
30 hours or more	1	3.0
20 hours	2	1.5

[1] Times hemodialysis rate.

CAPD, continuous cycling peritoneal disease (CCPD), and other techniques would be paid for on a weekly basis at three times the proposed treatment incentive payment rate.

Bad Debts

Hospitals with dialysis facilities are currently allowed to make a specific writeoff of medicare bad debts, for which a special payment is made at the end of the provider's accounting period. Medicare bad debts are those deductible and coinsurance amounts for which beneficiaries are liable and which, when uncollectable, result in providers being reimbursed less than costs. A provider must attempt to collect the amounts before bad debts are allowed as costs.

Under the proposed rule all dialysis facilities will be paid 100 percent of allowable Medicare bad debts, up to their reasonable costs, in a separate payment at the end of each facility's cost accounting period.

Patient Billing

Most home dialysis patients bill medicare directly for their supplies or equipment as allowed by the Social Security Act. These direct billing practices would continue to be permitted under the proposed regulations, although the composite rate would be more effective if all billing for the components of home dialysis service were to flow through a facility.

Home Dialysis Aides

Hemodialysis and intermittent peritoneal dialysis (IPD) patients require the assistance of an aide to dialyze at home. Most of these are assisted by family members who are not paid. Sometimes a home patient has no family and must have a paid aide. Although the cost of paid home aides was not included in setting the composite dialysis payment rates, the Secretary believes that the rates will provide a sufficient profit margin for facilities to furnish paid aides where they are warranted.

VI. ISSUES OF NOTE

Several issues relating to the proposed methodology have been raised.

(*a*) *Adequacy of HCFA audits* (p. 7)

Although the HCFA audits resulted in adjustments to independent facility costs, the U.S. General Accounting Office believes that more complete audits would have resulted in additional reductions. GAO made a limited review of 13 of the 38 independent facility audits performed by medicare fiscal intermediaries. None of the audits determined the actual costs to the related organizations selling dialysis supplies or the costs at which the supplies could be obtained from nonrelated organizations. The lower the related organization's costs or the price at which the supplies could be obtained elsewhere is the maximum allowable for medicare reimbursement purposes. Also, in many instances, home office and regional office costs reported by chain facilities were not audited. Therefore, substantial portions of costs were included in the cost reports without adequate assurance of compliance with medicare regulations concerning related organization costs. The total costs reported for those facilities were about $15.4 million. Work done by the intermediaries and HCFA resulted in reductions of about $2 million to the reported costs. Based on its limited review, GAO estimated that there should have been additional reductions of about $690,000.

(*b*) *Identification of efficient hospital-based vs. independent facilities* (p. 9)

To set economic rates, HCFA's basic approach was to identify the legitimate costs of what appeared to be economically and efficiently operated dialysis facilities and then, to make adjustments to reflect costs or savings attributable to operations as a hospital-based or independent facility. HCFA did not consider identifying the legitimate costs of what would appear to be economically and efficiently operated hospital-based facilities versus what would appear to be economically and efficiently operated independent facilities and then, in setting the rates, make adjustments to reflect the composite costs of home and infacility dialysis. Furthermore, because HCFA does not know what resource levels, e.g., patient-to-staff ratios, are appropriate for efficient and economical operations, HCFA had to rely on historical costs as an indicator of efficient and economical operations.

HCFA ascertains an efficient level of costs by considering the actual costs of all audited facilities—both hospital-based and independent. As a result the average payment per treatment for independent facilities is set at $128, twenty dollars higher than average costs for those facilities. Similarly, the average payment per treatment for hospital-based facilities is set at $132, three dollars less than average costs.

With respect to the Omnibus Reconciliation Act of 1981, the conference agreement on an incentive reimbursement rate for renal dialysis services reflects the concern of the Committee on Finance that a single composite rate would not foster home dialysis. The committee was

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concerned that hospital-based facilities would be driven from the market by a single rate which would not cover their costs. As a result, those facilities that support home dialysis would be replaced by independent facilities which generally do not treat patients in a home setting.

The proposal to base a dual rate on the median costs of all facilities and then adjusting that median to some extent for hospital-based facilities does not address the concerns of the committee. When the proposed rates are wage adjusted for the 105 sample facilities on which the rate is based, 50 of 64 hospital-based facilities will suffer losses of up to $800,000. Only 14 will experience a profit. The independent facilities will experience a profit in 28 of the 38 cases. Eight will suffer losses of less than $100,000.

NET EFFECT OF PROPOSED RATES ON SAMPLE FACILITIES

[In thousands of dollars]

	Hospital-based	Independent
Profits:		
Greater than 900		[1] 2
Greater than 800 but less than 900		
Greater than 700 but less than 800		
Greater than 600 but less than 700		1
Greater than 500 but less than 600		
Greater than 400 but less than 500		4
Greater than 300 but less than 400		1
Greater than 200 but less than 300		3
Greater than 100 but less than 200	3	6
Greater than 0 but less than 100	11	12
Subtotal	14	29
Losses:		
Greater than 0 but less than 100	32	8
Greater than 100 but less than 200	9	
Greater than 200 but less than 300	3	1
Greater than 300 but less than 400	3	
Greater than 400 but less than 500	1	
Greater than 500 but less than 600		
Greater than 600 but less than 700		
Greater than 700 but less than 800	1	
Greater than 800 but less than 900	1	
Greater than 900		
Subtotal	50	9
Total	[2] 64	38

[1] Profits for these facilities were $1.2 million and $1.7 million.

[2] Profits or losses could not be determined for three hospital-based facilities because wage indices were not available.

(*c*) *Differences in supply costs* (p. 9)

Median supply costs per treatment for hospital-based facilities exceeded median supply costs for independent facilities by $4. However, the difference may be justified in that hospital-based units may not be able to make greater use of volume purchasing.

Independent facilities provide greater volumes of treatment and are more likely than hospitals to be part of a chain organization. Both situations provide greater opportunities for volume purchasing which are not available to hospital-based facilities.

CHAIN OWNERSHIP AND TREATMENT VOLUME IN A SAMPLE OF 105 ESRD FACILITIES

	Hospital-based	Independent
Average number of treatment provided	4,602	9,409
Chain ownership	Nil	(1)

[1] 50 percent.

Preliminary 1980 data indicate the average number of stations is 7.5 per hospital-based facility and 13.2 for independent facilities. Similarly, the average output, in terms of treatments per unit, for hospitals was slightly over half the average output per independent facility. While the total output is similar, the individual units consist of many small hospital-based facilities, very few of which are members of chain organizations, and fewer but larger independent facilities, over half of which are members of chain organizations.

(*d*) *Patient case mix* (p. 10)

The question as to whether the level of resources necessary to provide outpatient dialysis is uniform among facilities or whether hospital-based facilities treat patients who are on the average sicker and require higher levels of staff and equipment has been a crucial question in ESRD reimbursement for a number of years.

Recent HCFA testimony before the House Subcommittee on Intergovernmental Relations indicates that the question may not have been resolved within HCFA, although the notion that patient differences are small and do not approach statistical significance is embodied in the proposed methodology.

According to Edmund G. Lowrie, and C. L. Hampers (New England Journal of Medicine, August 20, 1981), an analysis of HCFA's data describing patients undergoing dialysis in early 1980 shows that although independent facilities seem to have treated more black patients, one would be hard pressed to find clinically important differences to support the position that hospital-based facilities treat older patients with complicated disease. Their data show that nationally patients in either type facility are roughly the same age, have been on dialysis about the same length of time, and exhibit relatively the same incidence of various diagnoses.

A staff analysis of the same HCFA database, although updated to reflect patients undergoing dialysis through December 1980, was undertaken to test differences in utilization (incidence of hospitalization and length of stay), age, and incidence of diagnoses. Full details of the methodology and analysis will be made available at a later date. The analysis focused on differences

Between independent facilities and hospital-based facilities in major urban areas with 10 or more outpatient renal dialysis facilities and

Between facilities granted exceptions to the payment screen and facilities without exceptions to the screen in the same urban areas.

The analysis for differences was limited to major urban areas with 10 or more outpatient facilities on the assumption that on a national basis, difference in utilization, age, and incidence of diagnoses may be diminished. They may be diminished because there are many isolated outpatient facilities, both independent and hospital-based, which are sole source providers of outpatient dialysis. As such, both "sick" and "healthy" patients rely on these facilities for outpatient treatment. However, within major urban areas with many outpatient facilities, patients and their physicians could choose the type of facility for outpatients dialysis that best suited the patient's medical conditions. Hospital-based facilities that treated pediatric patients exclusively were not included in the analysis.

In accordance with medical advice provided by two nephrologists, patients whose primary diagnosis was initially reported as

Primary hypertension,
Diabetic nephropathy,
Collagen vascular disease,
Amyloidesis, or
Multiple myeloma

were considered to be "sicker" than "normal", more stable patients. Normal, more stable patients are those whose primary diagnosis was initially reported as

Glomerulonephritis,
Polycystic kidney disease,
Analgesic abuse nephropathy, or
Gouty nephropathy.

Because diagnostic information is only collected and reported with each facility's initial claim for reimbursement, the primary diagnosis reported may not an absolute indicator of a patient's medical condition at some later time. According to the nephrologists consulted, however, the primary diagnosis initially reported can be used as an indicator of whether a patient, over time, requires greater levels of medical resources.

An analysis of both sicker and normal patients, as defined by their primary diagnosis, shows that the patients defined as sicker do in fact incur higher rates of admission for inpatient care and are hospitalized for longer periods.

ESRD PATIENT HOSPITAL UTILIZATION IN 1980 IN MAJOR METROPOLITAN AREAS WITH 10 OR MORE ESRD FACILITIES

(Mean values)

	Number of—		Average length of stay
	Admissions	Inpatient days	
Patient definition based on primary diagnosis:			
Sicker	1.62	17.17	6.81
Undefined (diagnosis not reported)	1.42	14.51	6.12
Normal	1.28	13.08	5.46

Note: For patients on dialysis for all of 1980 only, excluding patients dialyzed in both types of facilities.

An analysis of the patient composition of hospital-based and independent facilities based on reported diagnosis is presented first.

Table 1 shows the distribution of treatments between hospital-based and independent facilities by patient diagnosis. The data in table 1 suggests that a higher percentage of treatments in independent facilities are for 'sicker' patients; conversely more treatments in hospital-based facilities are for 'normal' patients. This analysis was based on the number of dialysis treatments each patient received to avoid giving the same weight to patients on dialysis for the full year and patients on dialysis for part of the year. To simplify analysis, 1444 (7.6 percent) patients that were dialyzed at both types of facilities were eliminated from this analysis.

Table 2 shows the distribution of patients between facilities based on the patients primary diagnosis. Equal weight was given to each patient. Furthermore, patients dialyzed in both facility types were counted as hospital-based patients. This analysis also indicates that a higher percentage of independent facility patients were 'sicker' though in both analyses the differences in patient mix were small. It should be noted that for both analyses the primary diagnostic information was not reported for about 55 percent of the patients.

An analysis of the patient composition using inpatient hospitalization as a measure of patient condition supports a conclusion opposite to that indicated by the patient diagnosis data. Table 3 shows the average number of admissions, the average length of stay and the total number of inpatient days in 1980 for patients treated in each type of facility. The tables presents statistics which both include and exclude patients who were not on dialysis for the entire year. Patients who were treated in both types of facilities are excluded. The analyses shows that patients treated in hospital-based facilities are hospitalized at a higher rate and for longer periods than patients treated in inde-

pendent facilities. In this analysis, hospitalization information was available for all ESRD patients.

Since reported primary diagnosis and hospitalization data tended to agree as measures of morbidity, the different results obtained in these analyses appear to result from the 55 percent of cases for which primary diagnosis was not reported. For the group of patients for which primary diagnosis is not available, patients treated in hospital-based facilities are hospitalized at a higher rate and for longer periods than patients treated in independent facilities. This suggests that primary disease information is not reported systematically.

ESRD PATIENTS HOSPITAL UTILIZATION IN 1980 FOR PATIENTS WITH UNREPORTED PRIMARY DIAGNOSIS IN MAJOR METROPOLITAN AREAS WITH 10 OR MORE ESRD FACILITIES

	Hospital-based dialysis patients		Independent dialysis patients	
	With exception	No exception	With exception	No exception
Admissions:				
Mean	1.61	1.45	1.09	1.36
Standard error	.05	.05	.09	.03
Patient days:				
Mean	16.81	15.54	10.54	13.56
Standard error	.69	.64	1.20	.35
Length of stay:				
Mean	6.61	6.61	4.38	5.89
Standard error	.30	.30	.41	.15

Note: All patients treated in both types of facilities and all patients not on dialysis for the full year were eliminated from the analysis.

Conclusions based on the information presented here and on full details of the analysis and methodology to be made available later are left to the medical community and the Administrator of HCFA who are in a position to consider statistical versus clinical significance.

(*e*) *Overhead differential* (p. 10)

HCFA proposes to allow an overload differential of $2.10 per treatment between the median costs of hospitals alone and the median costs of the combined sample of hospital based and independent facilities. Had the proposed methodology based the rate for each type of facility on the median costs of each type of facility, the difference would have been $7.50.

(*f*) *Composite rate computation* (p. 10)

The percentage of home dialysis patients served by hospital-based facilities was applied to calculate a composite rate for those facilities. Likewise, the percentage of home dialysis patients served by independents was applied to calculate a composite rate for independent facilities.

Many experts believe that the home dialysis population could approach 30 to 40 percent within 5 to 7 years under an incentive system.

PERCENTAGE OF DIALYSIS PATIENTS SERVED IN VARIOUS SETTINGS

Facility	Setting	
	In-facility	Home
Independent	89.5	10.5
All (1981)	83.0	17.0
Hospital-based	76.5	23.5
All (projected)	60–70	30–40

Based on HCFA patient projections for fiscal year 1982 the composite rate as proposed increases the overall reimbursement to independent facilities by $8.7 million over the amount which would have been reimbursed if the composite rate was based on the national home dialysis experience.

(*g*) *Adjustment to median costs* (p. 11)

By selecting a median based on all facilities, the median cost for independents alone was "adjusted" upwards by 117 percent. According to HCFA, the significantly higher median accounts for any deficiencies in the data used. However, for hospital-based facilities HCFA applied an upward adjustment of only 105 percent to account for date deficiencies, and to soften the impact of a composite rate on hospital-based facilities.

APPENDIX A

ESRD Industry Characteristics

NUMBER OF ESRD FACILITIES

	1973	1978	1979	1980	1981
Hospital-based	536	638	645	649	654
Independent	68	275	330	405	466
Total	604	913	975	1,054	1,120

FACILITY CHARACTERISTICS

	Hospital-based	Independent
For-profit entities	5 percent	75 percent.
Treatments provided	47 percent	53 percent.
Average number of stations.	7.5	13.2.
Location	Evenly distributed.	Over 50 percent located in CA, NY, TX, PA, IL, FL, and GA. (11 States have no independents.)
Chain ownership	Very few	50 percent (The largest chain owns or operates about 1/3 of all independent facilities.)
Growth (1978–81)	16 facilities, 2.5 percent.	191 facilities, 69.5 percent.
Payment basis	Lower of cost or screen.	Lower of charges or screen.
Exceptions to screen	350 facilities, 54 percent	29 facilities, 6 percent
Average payment (1980).	$159	$138.
Median cost per treatment (audit sample).	$135.11	$107.66.
Home dialysis rate	23.5 percent	10.5 percent.
Average number of treatments (audit sample).	4,709	9,340.

TABLE 1
PERCENT OF TREATMENTS PROVIDED IN 1980
BY FACILITY TYPE AND PRIMARY DIAGNOSIS
IN MAJOR METROPOLITAN AREAS WITH 10 OR MORE ESRD FACILITIES

	HOSPITAL-BASED FACILITIES			INDEPENDENT FACILITIES			ALL FACILITIES		
PRIMARY DIAGNOSIS:	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL
Primary hypertension	13.33	7.68	10.82	9.51	13.30	13.11	12.83	12.03	12.23
Diabetic nephropathy	6.96	3.96	5.34	5.40	5.68	5.66	6.32	5.29	5.54
Collagen vascular disease	1.35	0.85	1.13	0.54	0.66	0.66	1.24	0.71	0.89
Amyloidesis	0.13	0.07	0.11	0.00	0.13	0.12	0.12	0.11	0.11
Multiple myeloma	0.12	0.14	0.13	0.03	0.10	0.10	0.11	0.11	0.11
Subtotal	21.39	12.71	17.52	15.48	19.87	19.64	20.62	18.25	18.83
Glomerulonephritis	16.03	11.50	14.01	18.16	12.09	12.36	16.31	11.32	12.99
Polycystic kidney disease	6.06	3.35	4.85	4.03	4.20	4.19	5.80	4.00	4.44
Analgesic abuse nephropathy	0.31	0.22	0.25	0.13	0.23	0.22	0.29	0.22	0.24
Gouty nephropathy	0.18	0.18	0.18	0.00	0.18	0.17	0.16	0.18	0.17
Subtotal	22.58	15.25	19.31	22.32	16.65	16.94	22.55	16.33	17.85
Other	10.96	7.29	9.33	7.42	8.23	8.24	10.50	8.06	8.65
Unreported	45.06	64.75	53.84	54.78	55.20	55.18	46.34	57.36	54.67
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
TREATMENTS	232,560	289,096	521,656	43,602	794,827	838,429	332,698	1,023,387	1,360,085

Note: All treatments for patients treated in both types of facilities were eliminated from the analysis.

TABLE 2
PERCENT OF PATIENTS TREATED IN 1980
BY FACILITY TYPE AND PRIMARY DIAGNOSIS
IN MAJOR METROPOLITAN AREAS WITH 10 OR MORE ESRD FACILITIES

	HOSPITAL-BASED FACILITIES			INDEPENDENT FACILITIES			ALL FACILITIES		
	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL
PRIMARY DIAGNOSIS:									
Primary hypertension	11.79	8.81	10.53	10.52	12.73	12.58	11.63	11.61	11.62
Diabetic nephropathy	7.19	4.94	6.25	6.65	6.21	6.24	7.13	5.85	6.24
Collagen vascular disease	1.22	0.70	1.00	0.72	0.77	0.76	1.16	0.75	0.88
Amyloidesis	0.18	0.08	0.14	0.00	0.19	0.18	0.16	0.16	0.16
Multiple myeloma	0.22	0.14	0.18	0.14	0.19	0.17	0.21	0.16	0.18
Subtotal	20.60	14.67	18.10	18.01	20.08	19.93	20.28	18.54	19.07
Glomerulonephritis	15.20	12.16	13.91	16.28	11.34	12.25	15.33	12.00	13.03
Polycystic kidney disease	4.85	3.11	4.11	3.75	4.42	4.38	4.72	4.05	4.25
Analgesic abuse nephropathy	0.39	0.19	0.31	0.14	0.31	0.30	0.36	0.28	0.30
Gouty nephropathy	0.22	0.27	0.24	0.00	0.18	0.17	0.19	0.21	0.20
Subtotal	20.65	15.73	18.58	20.17	16.06	17.09	20.60	16.54	17.79
Other	10.19	7.78	9.17	8.50	8.47	8.47	9.99	8.27	8.80
Unreported	48.56	61.82	54.15	55.31	54.59	54.50	49.13	56.65	54.34
TOTAL	100.000	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
PATIENTS	5,074	3,701	8,774	694	9,269	9,963	5,768	12,970	18,738

Note: Patients treated in both types of facilities were counted as hospital-based facility patients.

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TABLE 3
ESRD PATIENT HOSPITAL UTILIZATION IN 1980

BY FACILITY TYPE
IN MAJOR METROPOLITAN AREAS WITH 10 OR MORE ESRD FACILITIES

Note: All patients treated in both types of facilities were eliminated from the analysis.

	HOSPITAL-BASED FACILITIES			INDEPENDENT FACILITIES			ALL FACILITIES		
	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL	WITH EXCEPTION	WITHOUT EXCEPTION	TOTAL
ALL PATIENTS ON DIALYSIS FOR ALL OR PART OF 1980:									
Number of admissions									
Mean	1.55	1.44	1.50	1.19	1.32	1.31	1.50	1.35	1.39
Standard error	0.03	0.03	0.02	0.07	0.02	0.02	0.03	0.02	0.01
Number of inpatient days									
Mean	18.12	16.85	17.58	11.70	14.27	14.09	17.21	14.92	15.57
Standard error	0.49	0.46	0.32	0.84	0.25	0.24	0.40	0.22	0.19
Average length of stay									
Mean	7.53	7.56	7.54	4.88	6.29	6.19	7.15	6.61	6.76
Standard error	0.19	0.22	0.15	0.52	0.11	0.10	0.17	0.10	0.09
PATIENTS ON DIALYSIS FOR ALL OF 1980 ONLY:									
Number of admissions									
Mean	1.62	1.45	1.55	1.22	1.36	1.35	1.56	1.38	1.43
Standard error	0.04	0.04	0.03	0.08	0.02	0.02	0.03	0.02	0.02
Number of inpatient days									
Mean	17.39	15.45	16.54	11.41	13.57	13.41	16.42	14.04	14.69
Standard error	0.53	0.53	0.38	0.93	0.28	0.27	0.47	0.25	0.22
Average length of stay									
Mean	6.75	6.56	6.67	4.43	5.82	5.72	6.38	6.00	6.11
Standard error	0.21	0.24	0.16	0.30	0.11	0.11	0.18	0.10	0.09

APPENDIX B

ESRD Utilization and Reimbursement Statistics by State

This section summarizes attributes of ESRD facilities within each State for 1980. There are three kinds of statistics for each state, broken down by the type of provider—hospital-based versus independent facilities—and whether or not such facilities were granted a rate exception. The statistics were calculated in the aggregate for each facility type within each state.

The statistics, (1) indicate the extent of activities and services provided by facilities within each state, (2) indicate facility utilization for each facility type, and (3) indicate average reimbursement treatment rates. The Renal Dialysis Charge Index is a ratio of average reimbursement rates for a type of facility within a state divided by the national average (calculated similarly but over all treatments and reimbursements by all types of facilities during 1980).

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
NATIONAL PATIENT AND PROVIDER CHARACTERISTICS

FACILITIES FROM ALL STATES

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	944	47,369	3,867,960	12,080	3.92	320.20	$146.03	1.004
HOSPITAL BASED	559	23,449	1,752,648	5,942	3.95	294.96	$153.90	1.058
WITH EXCEPTIONS	314	12,991	955,859	3,343	3.89	285.93	$167.03	1.148
WITHOUT EXCEPTIONS	245	10,458	796,789	2,599	4.02	306.58	$138.16	0.950
INDEPENDENT	385	23,920	2,115,312	6,138	3.90	344.63	$139.50	0.959
WITH EXCEPTIONS	26	1,641	108,442	407	4.03	266.44	$166.05	1.141
WITHOUT EXCEPTIONS	359	22,279	2,006,870	5,731	3.89	350.18	$138.07	0.949

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN ALABAMA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	18	925	75,574	244	3.79	309.73	$138.28	0.950
HOSPITAL BASED	6	504	38,441	116	4.34	331.39	$138.54	0.952
WITH EXCEPTIONS	1	10	326	6	1.67	54.33	$202.00	1.388
WITHOUT EXCEPTIONS	5	494	38,115	110	4.49	346.50	$138.00	0.948
INDEPENDENT	12	421	37,133	128	3.29	290.10	$138.00	0.948
WITHOUT EXCEPTIONS	12	421	37,133	128	3.29	290.10	$138.00	0.948

FACILITIES IN ALASKA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	1	18	846	7	2.57	120.86	$203.26	1.397
INDEPENDENT	1	18	846	7	2.57	120.86	$203.26	1.397
WITH EXCEPTIONS	1	18	846	7	2.57	120.86	$203.26	1.397

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN ARIZONA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	12	600	52,548	140	4.29	375.34	$150.21	1.032
HOSPITAL BASED	7	293	26,972	67	4.37	402.57	$146.73	1.008
WITH EXCEPTIONS	6	220	19,931	53	4.15	376.06	$149.82	1.030
WITHOUT EXCEPTIONS	1	73	7,041	14	5.21	502.93	$138.00	0.948
INDEPENDENT	5	307	25,576	73	4.21	350.36	$153.88	1.058
WITH EXCEPTIONS	3	185	15,708	37	5.00	424.54	$163.86	1.126
WITHOUT EXCEPTIONS	2	122	9,868	36	3.39	274.11	$138.00	0.948

FACILITIES IN ARKANSAS	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	14	353	29,258	113	3.12	258.92	$142.75	0.981
HOSPITAL BASED	7	100	6,834	35	2.86	195.26	$158.32	1.088
WITH EXCEPTIONS	3	27	2,099	17	1.59	123.47	$204.16	1.403
WITHOUT EXCEPTIONS	4	73	4,735	18	4.06	263.06	$138.00	0.948
INDEPENDENT	7	253	22,424	78	3.24	287.49	$138.00	0.948
WITH EXCEPTIONS	1	46	3,909	11	4.18	355.36	$138.00	0.948
WITHOUT EXCEPTIONS	6	207	18,515	67	3.09	276.34	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN CALIFORNIA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	114	4,468	267,348	1,436	3.11	186.18	$157.01	1.079
HOSPITAL BASED	56	1,950	126,755	574	3.40	220.83	$174.31	1.198
WITH EXCEPTIONS	52	1,767	110,820	525	3.37	211.09	$179.53	1.234
WITHOUT EXCEPTIONS	4	183	15,935	49	3.73	325.20	$138.00	0.948
INDEPENDENT	58	2,518	140,593	862	2.92	163.10	$141.41	0.972
WITH EXCEPTIONS	6	262	14,899	87	3.01	171.25	$170.16	1.169
WITHOUT EXCEPTIONS	52	2,256	125,694	775	2.91	162.19	$138.00	0.948

FACILITIES IN COLORADO	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	10	562	45,243	127	4.43	356.24	$140.35	0.965
HOSPITAL BASED	5	191	13,093	53	3.60	247.04	$144.86	0.996
WITH EXCEPTIONS	2	48	2,196	15	3.20	146.40	$178.90	1.230
WITHOUT EXCEPTIONS	3	143	10,897	38	3.76	286.76	$138.00	0.948
INDEPENDENT	5	371	32,150	74	5.01	434.46	$138.52	0.952
WITH EXCEPTIONS	1	40	2,078	6	6.67	346.33	$146.00	1.003
WITHOUT EXCEPTIONS	4	331	30,072	68	4.87	442.24	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN CONNECTICUT	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	14	780	75,446	161	4.84	468.61	$143.38	0.985
HOSPITAL BASED	12	652	62,701	132	4.94	475.01	$144.47	0.993
WITH EXCEPTIONS	6	272	24,715	58	4.69	426.12	$154.41	1.061
WITHOUT EXCEPTIONS	6	380	37,986	74	5.14	513.32	$138.00	0.948
INDEPENDENT	2	128	12,745	29	4.41	439.48	$138.00	0.948
WITHOUT EXCEPTIONS	2	128	12,745	29	4.41	439.48	$138.00	0.948

FACILITIES IN DELAWARE	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	3	142	11,324	45	3.16	251.64	$138.00	0.948
HOSPITAL BASED	1	5	83	6	0.83	13.83	$138.00	0.948
WITHOUT EXCEPTIONS	1	5	83	6	0.83	13.83	$138.00	0.948
INDEPENDENT	2	137	11,241	39	3.51	288.23	$138.00	0.948
WITHOUT EXCEPTIONS	2	137	11,241	39	3.51	288.23	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN DISTRICT OF COLUMBIA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	12	704	61,829	210	3.35	294.42	$138.58	0.952
HOSPITAL BASED	5	79	4,844	57	1.39	84.98	$145.42	0.999
WITH EXCEPTIONS	2	9	388	15	0.60	25.87	$230.61	1.585
WITHOUT EXCEPTIONS	3	70	4,456	42	1.67	106.10	$138.00	0.948
INDEPENDENT	7	625	56,985	153	4.08	372.45	$138.00	0.948
WITHOUT EXCEPTIONS	7	625	56,985	153	4.08	372.45	$138.00	0.948

FACILITIES IN FLORIDA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	55	3,138	272,614	842	3.73	323.77	$139.82	0.961
HOSPITAL BASED	16	680	52,045	208	3.27	250.22	$145.08	0.997
WITH EXCEPTIONS	7	334	24,984	100	3.34	249.84	$150.43	1.034
WITHOUT EXCEPTIONS	9	346	27,061	108	3.20	250.56	$140.14	0.963
INDEPENDENT	39	2,458	220,569	634	3.88	347.90	$138.58	0.952
WITH EXCEPTIONS	1	33	2,837	10	3.30	283.70	$134.00	0.921
WITHOUT EXCEPTIONS	38	2,425	217,732	624	3.89	348.93	$138.64	0.953

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN GEORGIA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	26	1,429	129,451	446	3.20	290.25	$141.08	0.970
HOSPITAL BASED	9	347	23,130	102	3.40	226.76	$155.27	1.067
WITH EXCEPTIONS	4	164	10,273	55	2.98	186.78	$176.87	1.216
WITHOUT EXCEPTIONS	5	183	12,857	47	3.89	273.55	$138.00	0.948
INDEPENDENT	17	1,082	106,321	344	3.15	309.07	$138.00	0.948
WITHOUT EXCEPTIONS	17	1,082	106,321	344	3.15	309.07	$138.00	0.948

FACILITIES IN HAWAII	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	6	363	26,880	88	4.13	305.45	$143.11	0.984
HOSPITAL BASED	6	363	26,880	88	4.13	305.45	$143.11	0.984
WITH EXCEPTIONS	2	279	19,070	58	4.81	328.79	$145.20	0.998
WITHOUT EXCEPTIONS	4	84	7,810	30	2.80	260.33	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN IDAHO

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	1	49	2,866	6	8.17	477.67	$138.00	0.948
HOSPITAL BASED	1	49	2,866	6	8.17	477.67	$138.00	0.948
WITH EXCEPTIONS	1	49	2,866	6	8.17	477.67	$138.00	0.948

FACILITIES IN ILLINOIS

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	57	2,522	244,942	748	3.37	327.46	$148.31	1.019
HOSPITAL BASED	35	1,222	114,093	404	3.02	282.41	$159.85	1.099
WITH EXCEPTIONS	30	1,127	104,095	368	3.06	282.87	$161.95	1.113
WITHOUT EXCEPTIONS	5	95	9,998	36	2.64	277.72	$138.00	0.948
INDEPENDENT	22	1,300	130,849	344	3.78	380.38	$138.25	0.950
WITH EXCEPTIONS	2	60	4,478	22	2.73	203.55	$145.20	0.998
WITHOUT EXCEPTIONS	20	1,240	126,371	322	3.85	392.46	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN INDIANA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	10	872	66,621	187	4.66	356.26	$156.36	1.075
HOSPITAL BASED	10	872	66,621	187	4.66	356.26	$156.36	1.075
WITH EXCEPTIONS	3	370	31,761	71	5.21	447.34	$176.51	1.213
WITHOUT EXCEPTIONS	7	502	34,860	116	4.33	300.52	$138.00	0.948

FACILITIES IN IOWA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	8	310	24,879	92	3.37	270.42	$166.11	1.142
HOSPITAL BASED	8	310	24,879	92	3.37	270.42	$166.11	1.142
WITH EXCEPTIONS	7	275	22,431	82	3.35	273.55	$169.17	1.163
WITHOUT EXCEPTIONS	1	35	2,448	10	3.50	244.80	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1930 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN KANSAS	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	4	328	27,428	70	4.69	391.83	$158.86	1.092
HOSPITAL BASED	4	328	27,428	70	4.69	391.83	$158.86	1.092
WITH EXCEPTIONS	4	328	27,428	70	4.69	391.83	$158.86	1.092

FACILITIES IN KENTUCKY	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	12	404	27,791	122	3.31	227.80	$138.38	0.951
HOSPITAL BASED	5	60	2,664	30	2.00	88.80	$139.39	0.958
WITH EXCEPTIONS	1	9	84	7	1.29	12.00	$182.00	1.251
WITHOUT EXCEPTIONS	4	51	2,580	23	2.22	112.17	$138.00	0.948
INDEPENDENT	7	344	25,127	92	3.74	273.12	$138.28	0.950
WITH EXCEPTIONS	1	12	869	4	3.00	217.25	$146.00	1.003
WITHOUT EXCEPTIONS	6	332	24,258	88	3.77	275.66	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN LOUISIANA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	23	895	54,094	280	3.20	193.19	$138.35	0.951
HOSPITAL BASED	10	180	4,138	96	1.88	43.10	$142.55	0.980
WITH EXCEPTIONS	1	26	418	12	2.17	34.83	$183.00	1.258
WITHOUT EXCEPTIONS	9	154	3,720	84	1.83	44.29	$138.00	0.948
INDEPENDENT	13	715	49,956	184	3.89	271.50	$138.00	0.948
WITHOUT EXCEPTIONS	13	715	49,956	184	3.89	271.50	$138.00	0.948

FACILITIES IN MAINE (DATA NOT AVAILABLE)

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN MARYLAND	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	14	607	50,680	143	4.24	354.41	$137.71	0.946
HOSPITAL BASED	7	199	12,675	53	3.75	239.15	$136.86	0.941
WITH EXCEPTIONS	2	71	4,956	16	4.44	309.75	$135.08	0.928
WITHOUT EXCEPTIONS	5	128	7,719	37	3.46	208.62	$138.00	0.948
INDEPENDENT	7	408	38,005	90	4.53	422.28	$138.00	0.948
WITHOUT EXCEPTIONS	7	408	38,005	90	4.53	422.28	$138.00	0.948

FACILITIES IN MASSACHUSETTS	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	20	1,297	115,758	216	6.00	535.92	$146.29	1.005
HOSPITAL BASED	15	652	49,608	118	5.53	420.41	$157.35	1.081
WITH EXCEPTIONS	11	401	29,338	79	5.08	371.37	$170.71	1.173
WITHOUT EXCEPTIONS	4	251	20,270	39	6.44	519.74	$138.00	0.948
INDEPENDENT	5	645	66,150	98	6.58	675.00	$138.00	0.948
WITHOUT EXCEPTIONS	5	645	66,150	98	6.58	675.00	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN MICHIGAN

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	33	1,828	146,574	480	3.81	305.36	$150.85	1.037
HOSPITAL BASED	29	1,480	112,127	389	3.80	288.24	$154.48	1.062
WITH EXCEPTIONS	21	1,153	91,758	280	4.12	327.71	$157.42	1.082
WITHOUT EXCEPTIONS	8	327	20,369	109	3.00	186.87	$141.24	0.971
INDEPENDENT	4	348	34,447	91	3.82	378.54	$139.06	0.956
WITH EXCEPTIONS	1	65	4,544	18	3.61	252.44	$146.00	1.003
WITHOUT EXCEPTIONS	3	283	29,903	73	3.88	409.63	$138.00	0.948

FACILITIES IN MINNESOTA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	14	693	49,558	157	4.41	315.66	$175.17	1.204
HOSPITAL BASED	13	574	43,339	139	4.13	311.79	$178.35	1.226
WITH EXCEPTIONS	7	503	36,635	103	4.88	355.68	$185.73	1.276
WITHOUT EXCEPTIONS	6	71	6,704	36	1.97	186.22	$138.00	0.948
INDEPENDENT	1	119	6,219	18	6.61	345.50	$153.00	1.052
WITH EXCEPTIONS	1	119	6,219	18	6.61	345.50	$153.00	1.052

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN MISSISSIPPI

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	11	567	51,235	142	3.99	360.81	$141.30	0.971
HOSPITAL BASED	3	214	16,411	46	4.65	356.76	$148.32	1.019
WITH EXCEPTIONS	2	151	13,428	34	4.44	394.94	$150.61	1.035
WITHOUT EXCEPTIONS	1	63	2,983	12	5.25	248.58	$138.00	0.948
INDEPENDENT	8	353	34,824	96	3.68	362.75	$138.00	0.948
WITHOUT EXCEPTIONS	8	353	34,824	96	3.68	362.75	$138.00	0.948

FACILITIES IN MISSOURI

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	20	928	68,566	223	4.16	307.47	$145.48	1.000
HOSPITAL BASED	14	494	34,019	125	3.95	272.15	$152.64	1.049
WITH EXCEPTIONS	10	285	19,014	72	3.96	264.08	$164.19	1.128
WITHOUT EXCEPTIONS	4	209	15,005	53	3.94	283.11	$138.00	0.948
INDEPENDENT	6	434	34,547	98	4.43	352.52	$138.43	0.951
WITH EXCEPTIONS	1	29	1,871	10	2.90	187.10	$146.00	1.003
WITHOUT EXCEPTIONS	5	405	32,676	88	4.60	371.32	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN MONTANA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	4	76	4,839	25	3.04	193.56	$150.19	1.032
HOSPITAL BASED	4	76	4,839	25	3.04	193.56	$150.19	1.032
WITH EXCEPTIONS	3	63	4,172	23	2.74	181.39	$152.14	1.046
WITHOUT EXCEPTIONS	1	13	667	2	6.50	333.50	$138.00	0.948

FACILITIES IN NEBRASKA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	8	216	15,862	64	3.38	247.84	$173.03	1.189
HOSPITAL BASED	8	216	15,862	64	3.38	247.84	$173.03	1.189
WITH EXCEPTIONS	8	216	15,862	64	3.38	247.84	$173.03	1.189

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN NEVADA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	3	250	16,833	47	5.32	358.15	$188.02	1.292
HOSPITAL BASED	3	250	16,833	47	5.32	358.15	$188.02	1.292
WITH EXCEPTIONS	3	250	16,833	47	5.32	358.15	$188.02	1.292

FACILITIES IN NEW HAMPSHIRE

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	2	107	8,734	17	6.29	513.76	$154.25	1.060
HOSPITAL BASED	1	29	2,151	6	4.83	358.50	$204.00	1.402
WITH EXCEPTIONS	1	29	2,151	6	4.83	358.50	$204.00	1.402
INDEPENDENT	1	78	6,583	11	7.09	598.45	$138.00	0.948
WITHOUT EXCEPTIONS	1	78	6,583	11	7.09	598.45	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN NEW JERSEY

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	24	2,051	167,105	345	5.94	484.36	$143.24	0.984
HOSPITAL BASED	18	1,448	106,369	239	6.06	445.06	$146.24	1.005
WITH EXCEPTIONS	6	530	38,452	87	6.09	441.98	$160.79	1.105
WITHOUT EXCEPTIONS	12	918	67,917	152	6.04	446.82	$138.00	0.948
INDEPENDENT	6	603	60,736	106	5.69	572.98	$138.00	0.948
WITHOUT EXCEPTIONS	6	603	60,736	106	5.69	572.98	$138.00	0.948

FACILITIES IN NEW MEXICO

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	9	230	17,024	68	3.38	250.35	$143.51	0.986
HOSPITAL BASED	6	120	7,714	40	3.00	192.85	$150.16	1.032
WITH EXCEPTIONS	2	48	3,673	17	2.82	216.06	$163.54	1.124
WITHOUT EXCEPTIONS	4	72	4,041	23	3.13	175.70	$138.00	0.948
INDEPENDENT	3	110	9,310	28	3.93	332.50	$138.00	0.948
WITHOUT EXCEPTIONS	3	110	9,310	28	3.93	332.50	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN NEW YORK

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	77	4,470	396,757	851	5.25	466.22	$142.88	0.982
HOSPITAL BASED	64	3,044	245,062	582	5.23	421.07	$147.70	1.015
WITH EXCEPTIONS	19	748	60,276	142	5.27	424.48	$177.44	1.219
WITHOUT EXCEPTIONS	45	2,296	184,786	440	5.22	419.97	$138.00	0.948
INDEPENDENT	13	1,426	151,695	269	5.30	563.92	$135.08	0.928
WITH EXCEPTIONS	4	404	29,611	97	4.16	305.27	$123.05	0.846
WITHOUT EXCEPTIONS	9	1,022	122,084	172	5.94	709.79	$138.00	0.948

FACILITIES IN NORTH CAROLINA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	18	1,244	103,470	306	4.07	338.14	$166.18	1.142
HOSPITAL BASED	8	309	21,881	73	4.23	299.74	$171.86	1.181
WITH EXCEPTIONS	6	282	20,027	69	4.09	290.25	$174.99	1.203
WITHOUT EXCEPTIONS	2	27	1,854	4	6.75	463.50	$138.00	0.948
INDEPENDENT	10	935	81,589	233	4.01	350.17	$164.66	1.132
WITH EXCEPTIONS	1	113	11,887	33	3.42	360.21	$321.00	2.206
WITHOUT EXCEPTIONS	9	822	69,702	200	4.11	348.51	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN NORTH DAKOTA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	4	89	7,532	23	3.87	327.48	$145.43	1.000
HOSPITAL BASED	4	89	7,532	23	3.87	327.48	$145.43	1.000
WITH EXCEPTIONS	2	51	4,347	15	3.40	289.80	$150.88	1.037
WITHOUT EXCEPTIONS	2	38	3,185	8	4.75	398.13	$138.00	0.948

FACILITIES IN OHIO	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	31	1,883	138,613	435	4.33	318.65	$150.68	1.036
HOSPITAL BASED	24	1,245	79,313	303	4.11	261.76	$160.16	1.101
WITH EXCEPTIONS	15	788	52,551	191	4.13	275.14	$171.45	1.178
WITHOUT EXCEPTIONS	9	457	26,762	112	4.08	238.95	$138.00	0.948
INDEPENDENT	7	638	59,300	132	4.83	449.24	$138.00	0.948
WITHOUT EXCEPTIONS	7	638	59,300	132	4.83	449.24	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN OKLAHOMA	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	15	422	26,383	113	3.73	233.48	$151.33	1.040
HOSPITAL BASED	12	293	20,550	85	3.45	241.76	$155.12	1.066
WITH EXCEPTIONS	7	218	17,890	59	3.69	303.22	$157.67	1.084
WITHOUT EXCEPTIONS	5	75	2,660	26	2.88	102.31	$138.00	0.948
INDEPENDENT	3	129	5,833	28	4.61	208.32	$138.00	0.948
WITHOUT EXCEPTIONS	3	129	5,833	28	4.61	208.32	$138.00	0.948

FACILITIES IN OREGON	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	7	320	24,625	95	3.37	259.21	$150.64	1.035
HOSPITAL BASED	4	192	12,555	55	3.49	228.27	$162.78	1.119
WITH EXCEPTIONS	3	177	11,393	49	3.61	232.51	$165.31	1.136
WITHOUT EXCEPTIONS	1	15	1,162	6	2.50	193.67	$138.00	0.948
INDEPENDENT	3	128	12,070	40	3.20	301.75	$138.00	0.948
WITHOUT EXCEPTIONS	3	128	12,070	40	3.20	301.75	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN PENNSYLVANIA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	60	2,872	256,874	754	3.81	340.68	$143.66	0.987
HOSPITAL BASED	35	1,396	102,238	363	3.85	281.65	$152.21	1.046
WITH EXCEPTIONS	14	644	43,478	159	4.05	273.45	$171.43	1.178
WITHOUT EXCEPTIONS	21	752	58,760	204	3.69	288.04	$138.00	0.948
INDEPENDENT	25	1,476	154,636	391	3.77	395.49	$138.00	0.948
WITHOUT EXCEPTIONS	25	1,476	154,636	391	3.77	395.49	$138.00	0.948

FACILITIES IN RHODE ISLAND

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	4	347	31,664	76	4.57	416.63	$138.02	0.949
HOSPITAL BASED	2	31	1,374	13	2.38	105.69	$138.54	0.952
WITH EXCEPTIONS	1	0	23	4	0.00	5.75	$170.00	1.168
WITHOUT EXCEPTIONS	1	31	1,351	9	3.44	150.11	$138.00	0.948
INDEPENDENT	2	316	30,290	63	5.02	480.79	$138.00	0.948
WITHOUT EXCEPTIONS	2	316	30,290	63	5.02	480.79	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN SOUTH CAROLINA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	12	610	52,515	168	3.63	312.59	$138.00	0.948
HOSPITAL BASED	3	108	7,238	29	3.72	249.59	$138.00	0.948
WITHOUT EXCEPTIONS	3	108	7,238	29	3.72	249.59	$138.00	0.948
INDEPENDENT	9	502	45,277	139	3.61	325.73	$138.00	0.948
WITHOUT EXCEPTIONS	9	502	45,277	139	3.61	325.73	$138.00	0.948

FACILITIES IN SOUTH DAKOTA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	5	82	6,613	24	3.42	275.54	$138.23	0.950
HOSPITAL BASED	5	82	6,613	24	3.42	275.54	$138.23	0.950
WITH EXCEPTIONS	2	25	1,714	9	2.78	190.44	$138.89	0.955
WITHOUT EXCEPTIONS	3	57	4,899	15	3.80	326.60	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN TENNESSEE

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	18	1,065	85,312	296	3.60	288.22	$137.85	0.947
HOSPITAL BASED	7	325	23,344	113	2.88	206.58	$137.45	0.945
WITH EXCEPTIONS	5	120	6,070	51	2.35	119.02	$135.87	0.934
WITHOUT EXCEPTIONS	2	205	17,274	62	3.31	278.61	$138.00	0.948
INDEPENDENT	11	740	61,968	183	4.04	338.62	$138.00	0.948
WITHOUT EXCEPTIONS	11	740	61,968	183	4.04	338.62	$138.00	0.948

FACILITIES IN TEXAS

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	58	3,267	303,942	892	3.66	340.74	$138.30	0.951
HOSPITAL BASED	26	962	82,159	303	3.17	271.15	$139.11	0.956
WITH EXCEPTIONS	6	100	6,922	45	2.22	153.82	$151.17	1.039
WITHOUT EXCEPTIONS	20	862	75,237	258	3.34	291.62	$138.00	0.948
INDEPENDENT	32	2,305	221,783	589	3.91	376.54	$138.00	0.948
WITHOUT EXCEPTIONS	32	2,305	221,783	589	3.91	376.54	$138.00	0.948

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN UTAH

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	6	225	13,632	60	3.75	227.20	$138.00	0.948
INDEPENDENT	6	225	13,632	60	3.75	227.20	$138.00	0.948
WITHOUT EXCEPTIONS	6	225	13,632	60	3.75	227.20	$138.00	0.948

FACILITIES IN VERMONT

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	1	68	4,176	11	6.18	379.64	$140.00	0.962
HOSPITAL BASED	1	68	4,176	11	6.18	379.64	$140.00	0.962
WITH EXCEPTIONS	1	68	4,176	11	6.18	379.64	$140.00	0.962

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN VIRGINIA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	29	1,453	132,511	353	4.12	375.39	$138.96	0.935
HOSPITAL BASED	9	520	38,327	113	4.60	339.18	$141.31	0.971
WITH EXCEPTIONS	1	60	5,281	19	3.16	277.95	$162.00	1.113
WITHOUT EXCEPTIONS	8	460	33,046	94	4.89	351.55	$138.00	0.948
INDEPENDENT	20	933	94,184	240	3.89	392.43	$138.00	0.948
WITHOUT EXCEPTIONS	20	933	94,184	240	3.89	392.43	$138.00	0.948

FACILITIES IN WASHINGTON

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	7	383	10,873	79	4.85	137.63	$161.28	1.108
HOSPITAL BASED	6	142	3,121	37	3.84	84.35	$176.88	1.216
WITH EXCEPTIONS	6	142	3,121	37	3.84	84.35	$176.88	1.216
INDEPENDENT	1	241	7,752	42	5.74	184.57	$155.00	1.065
WITH EXCEPTIONS	1	241	7,752	42	5.74	184.57	$155.00	1.065

SENATE FINANCE COMMITTEE'S REPORT ON END-STAGE RENAL DIALYSIS
1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN WEST VIRGINIA

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	8	185	13,975	82	2.26	170.43	$138.00	0.948
HOSPITAL BASED	5	116	8,857	52	2.23	170.33	$138.00	0.948
WITHOUT EXCEPTIONS	5	116	8,857	52	2.23	170.33	$138.00	0.948
INDEPENDENT	3	69	5,118	30	2.30	170.60	$138.00	0.948
WITHOUT EXCEPTIONS	3	69	5,118	30	2.30	170.60	$138.00	0.948

FACILITIES IN WISCONSIN

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	21	658	47,809	166	3.96	288.01	$164.51	1.131
HOSPITAL BASED	20	590	41,894	149	3.96	281.17	$168.26	1.156
WITH EXCEPTIONS	18	554	38,433	137	4.04	280.53	$170.98	1.175
WITHOUT EXCEPTIONS	2	36	3,461	12	3.00	288.42	$138.00	0.948
INDEPENDENT	1	68	5,915	17	4.00	347.94	$138.00	0.948
WITHOUT EXCEPTIONS	1	68	5,915	17	4.00	347.94	$138.00	0.948

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1980 OUTPATIENT FULL-CARE STAFF ASSISTED HEMODIALYSIS
PATIENT AND PROVIDER CHARACTERISTICS BY STATE

FACILITIES IN WYOMING

	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	NUMBER OF TREATMENTS	NUMBER OF STATIONS	PATIENTS PER STATION	TREATMENTS PER STATION	AVERAGE CHARGE PER TREATMENT	DIALYSIS CHARGE INDEX
ALL FACILITIES	1	14	934	5	2.80	186.80	$189.00	1.299
INDEPENDENT	1	14	934	5	2.80	186.80	$189.00	1.299
WITH EXCEPTIONS	1	14	934	5	2.80	186.80	$189.00	1.299